Akari Care Limited

Ashfield Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 1 and 9 March 2017 and was unannounced.

We last carried out a comprehensive inspection of this service in November 2015 where we found the provider was not meeting the regulations relating to safe care and treatment, good governance and staffing. In addition, the provider had not sent us notifications which they are legally required to do as part of their registration. We undertook a focused inspection on 14 June 2016 and found that improvements had been made and they were now meeting legal requirements. We did not change the home's overall rating at the focused inspection because to do so requires consistent good practice over time.

Ashfield Court provides residential care for up to 46 people, some of whom are living with dementia. Accommodation was spread over two floors. People who were living with dementia lived on first floor. At the time of our inspection there were 44 people living at the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was currently overseeing the management of one of the provider's nearby nursing homes. He explained that there was the possibility of him becoming manager at this nursing home. As a result, an 'interim manager' had been appointed who the registered manager explained would eventually take over his role as manager at Ashfield Court and would register with CQC. She had worked at the service for a number of years. We were supported by both the registered manager and interim manager on both days of the inspection.

On the first day of our inspection, we spoke with people, relatives and day staff who were positive about the home. Following our first visit, we spoke with night staff so we could ascertain how care and support was delivered at night. Certain night staff said that day staff expected them to get most people with a dementia related condition up and dressed in the morning. As a result of this information we carried out another visit to the home at 7.30am.

On the second day of the inspection, we found that most people who lived in the unit for people with a dementia related condition were up and dressed by 7.30am. We spoke with staff who told us they had woken some people at 5am to get them up and dressed.

There were safeguarding and whistleblowing procedures in place. Day staff told us that they had no safeguarding concerns. Certain night staff however, raised several safeguarding allegations. Some night staff told us that they had raised concerns in the past about specific staff and care practices; however no action had been taken. Other staff told us that they had not felt able to raise specific concerns. We passed their

concerns to the local authority's safeguarding team, the registered manager and members of the provider's senior management team to investigate.

Checks and tests had been carried out to ensure that the premises were safe. An electronic medicines system was used to manage medicines. We found there was a safe and effective system in place for the receipt, storage, administration and disposal of medicines.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people. We checked staff rotas and noted that staffing levels were not always maintained at the numbers advised by the manager. He told us that due to last minute sickness, it was not always possible to get staffing cover. He said they were over recruiting to help ensure they could cover all shifts at the home. We have made a recommendation about this.

Records demonstrated that most staff had completed training in safe working practices and to meet the specific needs of people who lived at the home. There were some gaps in training provision which the interim manager told us she was addressing. Most of the night staff told us that they did not always feel supported in their job role. We found that an effective system to develop, monitor and review staff practices and behaviours was not fully in place to ensure staff were supported to deliver care which met people's needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. Appropriate applications for DoLS had been made by the registered manager. There was evidence that some mental capacity assessments and best interests decisions had been undertaken. However, these were generic and not specific.

People's nutritional needs were met and they were supported to access healthcare services when required.

We observed positive interactions between staff and people who lived at the service on both days of our inspection. Staff told us that they promoted people's privacy and dignity. However, the practice of assisting some people up early did not promote dignity or person centred care.

People and relatives told us that they were involved in people's care. This was not always evidenced in the records we viewed.

People and relatives told us that activities provision had improved since the new activities coordinator had started. We had concerns however, about one person's social inclusion and wellbeing.

There was a complaints procedure in place. None of the people or relatives with whom we spoke raised any concerns.

Audits and checks were carried out to monitor all aspects of the service. We found however, that these audits and checks had not highlighted the issues which had been identified during this inspection such as the culture and morale on night shift and concerns with certain staff practices and behaviours. We also identified shortfalls with certain aspects of record keeping.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These related to person centred care, safeguarding people from abuse and improper treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were safeguarding procedures in place. However, these were not always followed when concerns were identified.

Staffing levels were not always maintained. Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

Medicines were managed safely. Checks and tests had been carried out to ensure that equipment and the premises were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

An effective appraisal and supervision system was not fully in place. Certain night staff felt unsupported.

There was evidence that some mental capacity assessments and best interests decisions had been undertaken. However, these were generic and not specific.

People's nutritional needs were met and they were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Certain staff practices did not promote people's dignity or reflect the caring ethos of the home. Certain night staff told us that some people who were living with dementia were woken early.

People and relatives told us that staff were caring. We saw kind and caring interactions between people and staff.

People and relatives told us that they were involved in people's care. This was not always evidenced in the records we viewed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Certain care practices were task focused rather than person-centred.

An activities programme was in place. However, we had concerns about one person's social inclusion and wellbeing.

There was a complaints procedure in place. None of the people or relatives with whom we spoke raised any concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in post. He was currently overseeing the management of one of the provider's nearby nursing homes. However, he still visited Ashfield Court daily. An interim manager had been appointed.

Audits and checks were carried out to monitor all aspects of the service. We found however, that these audits and checks had not highlighted the issues which had been identified during this inspection such as the culture and morale on night shift and concerns with certain staff practices and behaviours.

We found that records were not always well maintained.

Ashfield Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 1 and 9 March 2017. The inspection was unannounced and carried out by one inspector.

Prior to the inspection we checked all the information which we had received about the service, including the notifications which the provider had sent us. Notifications are changes, events or incidents that the provider is legally obliged to tell us about. The submission of notifications is a requirement of the law. Notifications enable us to monitor any trends or concerns within the service.

The registered manager completed a provider information return (PIR) prior to the inspection due to the late scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

We spoke with the registered manager, regional manager, the interim manager, two senior care workers, four care workers and the activities coordinator. We spoke with 10 people and four relatives. Following our first visit we spoke with eight night care workers.

We looked at four care plans in depth and looked at specific sections of a further nine care plans. We also checked information relating to staff training, staff recruitment and audits and checks relating to the management of the service and the premises.

We spoke with the local authority's contracts and commissioning officer, safeguarding officer, coroner's officer and member of staff from the district nursing team.

Requires Improvement

Is the service safe?

Our findings

On the first day of our inspection, we spoke with people, relatives and day staff who told us that people were safe at the home. There were safeguarding and whistleblowing procedures in place and day staff told us that they had not witnessed anything which concerned them.

Following our first visit, we spoke with night staff so we could ascertain how care and support was delivered at night. They raised a number of safeguarding concerns regarding people's care and treatment. Some staff told us that they had reported their concerns to the management team, others said they had not since they considered that no action would be taken by the managers in response to their concerns. One staff member said, "I haven't reported anything – because nothing happens." We passed their concerns to the local authority's safeguarding team, the registered manager of the home and members of the provider's senior management team. We cannot report on these at the time of the inspection. We will however, monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

We spent time reading people's care plans and daily records. We noted that a staff member had recorded in one person's records that they had been found locked in another person's room. The other person was not in their room at the time. Several staff told us that this had been reported to the interim manager. We spoke with both the registered manager and the interim manager who told us they were unaware of this incident and it had not been recorded in the registered manager's handover records. No incident record had been completed.

We considered that people were not fully protected against the risk of abuse because safeguarding procedures were not always followed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13. Safeguarding people from abuse.

A number of risk assessments were in place for areas such as falls, malnutrition and pressure ulcers. These had been identified through the assessment and care planning process. We checked one person's care documentation who had been at the home on a short stay placement. He had fallen a number of times over several months. Staff assessed them as being at "medium" risk of falls. The risk assessment stated that a falls care plan should be completed. We saw this had not been completed. The registered manager told us that this was because the 'short stay' paper work had been completed and not the full care planning documentation. The lack of a documented falls care plan meant it was difficult to ascertain what actions were required to reduce the risk of falls.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

We checked staffing levels at the service. The registered manager told us there were normally seven care staff on duty through the day and five at night. We received mixed feedback from people, relatives and staff

about staffing levels. One person said, "Without doubt there is enough staff." Another person said, "Even through the night at 3am, they come straight away." A relative said, "There is times when they don't have enough staff." Another relative said, "Sometimes I feel they could do with more staff."

We spoke with night staff who told us that although they could manage with five staff on duty, sometimes staffing levels dropped to four. We checked staff rotas and noted that staffing levels were not always maintained at the numbers advised by the registered manager . He told us that due to last minute sickness, it was not always possible to get staffing cover. He said they were over recruiting to help ensure they could cover all shifts at the home. Following the inspection, the manager wrote to us and stated, "The staffing level for the home [at night] is five and this is only to make sure that the actual level of four staff is maintained during the night if someone phones in sick."

During the day, we observed staff carry out their duties in a calm unhurried manner with the exception of the lunch time period in the unit for people who were living with dementia. There were two staff upstairs assisting people with their lunch. Some required assistance with eating and drinking whilst others required supervision and prompting. Both staff were very busy ensuring people had sufficient amounts to eat and drink. We asked staff whether there were usually only two staff upstairs at meal times. They told us that normally the senior care worker was also available to help. We spoke with the manager who told us the senior care worker had been required to assist downstairs because a new person had moved into the home and another person required three staff to help them.

We recommend that staffing levels are monitored to ensure there are sufficient staff deployed to meet the needs of people.

We spent time checking the premises and equipment. Checks and tests had been carried out on the premises and equipment to ensure they were safe. Personal emergency evacuation plans were in place which detailed how people should be supported to leave the building in the event of an emergency. One person was registered deaf. Staff placed a special device under her pillow at night which vibrated if the fire alarm sounded.

We examined the management of medicines. An electronic system was used to manage medicines. Medicines were recorded, administered, tracked and audited all on the single electronic system. Staff explained that this system helped reduce the risk of medicines errors and also prevented over or under stocking of medicines. Staff scanned bar codes on people's medicines to ensure the correct medicine was always given to the correct person. One staff member said, "You have to scan it first to make sure that you have the right resident and if you scan something like paracetamol, 10 minutes early before it's due, it will go 'uh oh' and it won't let you administer it." There was an automated warning system to alert staff if medicines were overdue or had not been administered. One person required their medicines at specific times throughout the day because of their medical condition. We saw that these were given on time and as prescribed. The home had scored 100% in a recent medicines audit. We considered there was a safe system in place for the receipt, storage, administration and disposal of medicines.

Staff told us, and records confirmed that the correct recruitment procedures were carried out before they started work. We saw that Disclosure and Barring Service [DBS] checks had been obtained prior to staff commencing in their roles. A DBS check is a report which details any offences which may prevent the person from working with vulnerable people. They help providers make safer recruitment decisions. Two written references had also been received. Risk assessments had been completed where any concerns were identified during recruitment checks. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified

and of suitable character to do their jobs.

Requires Improvement

Is the service effective?

Our findings

Staff informed us they felt equipped to carry out their roles and said that there was sufficient training available. Comments included, "I've done my level 2 and 3 [health and social care vocational training levels]. I've done the dementia booklets and I've done palliative care and medicines," "We have loads of training. I'm doing end of life" and "There is enough training, I always like to do training."

The manager provided us with information which showed that most staff had completed training in safe working practices and subject areas to meet the specific needs of people who used the service, such as dementia care. We noticed that there were some gaps in training provision. The interim manager told us that training was being organised and this would be addressed. Some staff told us that they could not remember if they had completed training in challenging behaviour. The registered manager told us that this area was covered in their restrictive practice training. Staff told us and records confirmed that induction training was carried out to ensure staff had the right skills to look after people competently and safely.

Several night staff raised concerns that the correct moving and handling procedures were not always followed for one individual. We passed this information to the local authority, registered manager and provider's representatives to investigate.

Day staff told us they felt supported in their roles. They said they had supervision sessions and an annual appraisal. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

Most of night staff however, told us they did not always feel supported. We checked all of night staff's personnel records and noted there was no evidence of any supervision or appraisals in some of the files we checked. In others, there was only one recorded supervision. The manager told us that they were changing the supervision and appraisal system. A quarterly system of supervision was going to be put into place. New appraisal documentation had been introduced which was confirmed by our own observations. He also explained that because of the concerns and issues raised by night staff, he would carry out monthly supervision sessions with staff to ensure they were supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had assessed whether people's plan of care amounted to a deprivation and had submitted DoLS applications to the local authority in line with legal requirements.

There was evidence that some mental capacity assessments and best interests decisions had been undertaken. However, these were generic and not specific. We read best interests' decisions in some people's care plans which stated, "This best interests is in place to allow staff to be able to make a decision that acts in the best interests for the resident." It was not clear however, what decisions staff could make for those people.

We noticed some people had sensor mats in place which alerted staff if they were at risk of falling and one person had a door alarm fitted which sounded if they came out of their room. In addition, staff used 'wedge pillows' to help prevent two people from falling out of bed. These are forms of restrictive practice since they can restrict or control a person's freedom of movement. Restrictive practices are only lawful if they are the least restrictive means of providing the care a person needs. There was limited documented evidence to determine what processes staff had followed to demonstrate they were following the requirements of the MCA. Mental capacity assessments were not completed for all specific decisions and often best interests' decisions had been decided by one staff member. There was limited evidence that discussions had been held with people's care managers or their legal representatives.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

We checked how people's nutritional needs were met. Most people and relatives were complimentary about the meals. Comments included, "He's put on weight since he has been here," "The food is very nice" and "Excellent food." One person told us he was a "fussy eater" and did not always enjoy the meals.

We observed that staff supported people with their dietary needs. On the first day of our inspection, we saw the lunch time meal in the unit for people living with dementia was rushed because there were only two staff to assist people.

People's weight was monitored and action was taken if any concerns were identified. This meant that systems were in place to monitor people's dietary needs and ensure they received a suitable nutritious diet.

People and relatives told us that staff contacted health and social care professionals when appropriate, to meet their needs. We saw evidence that staff had worked with various agencies and accessed other services when people's needs had changed, for example, consultants, GP's, challenging behaviour nurses, district nurses, speech and language therapists, dietitians, the chiropodist and dentist. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met to maintain their health.

The environment was effectively designed to meet the needs of people who used the service. Attention had been paid to the 'dementia friendly' design in the unit for people who were living with dementia. This included effective signage to highlight bathrooms and toilets to enable people to locate them easily. There were various themed corridors with bright pictures of the beach, animals and holidays. Tactile objects were also displayed for people to touch and feel on their walks around the home.

Requires Improvement

Is the service caring?

Our findings

People and relatives were complimentary about the caring nature of staff. Comments included, "The carers are caring," "They are always approachable. He is very happy here, he loves it," "When he comes home to our house for visits, our house isn't his home anymore, he wants to come home - to here" and "They're caring - it's their attitude. They're always friendly," We spoke with one person and his wife. He told us, "I'm very happy here, the staff are absolutely brilliant." His wife said, "He loves them all, they are all his sweethearts and darlings." Another relative said, "They are so good with that [dignity] if she needs changed they come straight away and do that."

Following our visit to the home, we spoke with night staff who raised concerns about certain staff practices and behaviours which did not promote people's dignity or reflect the caring ethos of the home.

We carried out a second visit to the home and found that staff were assisting people out of bed early because of an expectation by day staff. We read one person's care plan which stated they were a "late riser." One staff member said, "I wish we could just change them if they are wet and put them back to bed." This meant that care was not always person centred and did not meet the specific needs of people.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

The registered manager and interim manager told us that they were not aware that this practice was happening and there had been no instruction to night staff to get people up so early in the morning. The registered manager and regional manager told us that this would be addressed. Following the inspection, the manager wrote to us and stated that people who were assisted up early were those who were already up and walking around or those who required support with personal care following any episodes of incontinence.

We spent time observing the lunch time experience for people with a dementia related condition. We noted that one person wiped their face and hands on the table cloth because napkins were not available. In addition, some of the interactions were rushed because there were only two staff upstairs assisting with lunch. We spoke with the registered manager about our observations. He told us that cloth napkins had been removed because people had tried to eat them. On the second day of our inspection, napkins were now available.

On both days of our inspection we observed that staff were kind towards people. One person's physical and mental health had deteriorated. The interim manager sat with her and plaited her hair. On the second day of our inspection, one person laughed when the male senior care worker asked whether she would like him to put rollers in her hair. She told him that she would leave this to the hairdresser! There were positive comments from people to staff. We heard one person who was living with dementia tell a staff member, "You're the best girl in the world." Another person held a staff member's hand and kissed her arm and said, "Lovely girl."

Staff spoke positively about the people they cared for. One staff member said, "I love to know that I am here to help. Just to see a smile on their faces; it's so nice and rewarding." Another staff member said, "I'm here for the residents...I like to talk to them and find out all about them."

Records of compliments were kept. We read one letter which had been sent by a member of the public following their observations of a care worker who had accompanied a person to hospital during the night. This stated, "I was waiting at [name of hospital] during the early hours of [date] and was in a waiting area…I was so impressed with [name of staff] kindness, patience and care of [name of person]…[Name of staff member] really is an assistant who cares and is an asset to your care home."

People and relatives told us they were involved in people's care. One relative said, "I am very involved, I come every day." Another said, "They involve me in his care. I still do bits and pieces for him." It was not always clear however, from records we viewed, how people and relatives were involved in people's care. The manager told us that they were implementing new paperwork to demonstrate people and relatives' involvement.

At the time of our inspection no one accessed the services of an advocate, but we saw more informal means of advocacy through regular contact with families. This meant that people were invited to be supported by those who knew them best. Advocates help to represent the views and wishes of people who are not able to express their wishes.

Requires Improvement

Is the service responsive?

Our findings

People who were able to communicate their opinions verbally told us that staff were responsive to their needs. They told us, "Thumbs up, I like it here – they're good," "It's brilliant, I'm just here for respite care, but the staff are lovely. If I needed respite care again, I would come back" and "Smashing staff, always very helpful." Relatives told us, "I can't fault them" and "I could praise them to the hilt all day."

When we spoke with people who lived in the ground floor unit, they told us that they could choose how they wanted to spend their day, including what time they wanted to get up and go to bed. One person said, "I suit myself when I get up and go to bed." A relative said, "If she doesn't want to get up they don't force her."

Following our first visit to the home, we spoke with night staff who raised concerns about certain staff practices which did not demonstrate that care was personalised to meet people's specific needs and preferences. People who were unable to verbally communicate their wishes, such as those who were living with dementia were woken up early by staff to get them up and dressed. They also told us that some of the care provided was task focused such as "the bath list." They explained there was an expectation to bathe some people as well as get them up in the morning. On the second day of our inspection, night staff had given six people baths or showers before we arrived at 7.30am.

We read people's care plans and noted a document entitled, "This is your life" with questions about people's background and life history had been given to people's relatives for completion. None of the documents had been completed in any of the files we viewed. The registered manager told us that the activities coordinator was going to help complete these with people and their relatives.

Staff had started to complete one page profiles which gave an overview of people's likes and dislikes. Hospital passports were also in place. These contained details of people's communication needs, together with medical and personal information. This document could then be taken to the hospital to make sure that all professionals were aware of the individual's needs. One staff member said however, "They're not always followed [hospital passports and care plans]. [Name's] communication passport says she likes to lie in, but we have to get her up." This was confirmed by the records we viewed. On the second day of our inspection, we saw she was sitting in the lounge at 7.30am. Staff told us they had assisted her to get up at 6.30am.

We considered that care was not always person centred and certain care was task centred rather than based on the needs of people.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

Staff were knowledgeable about people's needs and could describe their likes and dislikes to us. One staff member said, "The care plans are good, I always read them to see what they [people] like and don't like. [Name] likes watching football on Sky and he always has his buzzer next to him."

We checked how people's social needs were met. People told us that there was enough activities to occupy their attention. This was confirmed by most relatives. One relative said, "[Name of activities coordinator] is very good, please make sure you mention that" and "[Name of activities coordinator] is absolutely marvellous." Another relative said, "She [activities coordinator] does bingo, arts and crafts and she bakes with them and she has a proper tea service up here where they sit and recount their stories. It would be nice to have an activities person for up and downstairs." One person said, "They have a girl who comes round and does things. She's done my nails – look bright pink so I can see them." A relative told us however, that activities dropped when the activities coordinator was not around such as at the weekends.

A new activities coordinator was in place to help meet the social needs of people who lived at the home. She spoke enthusiastically about her role and the people she supported.. She told us, "They love music, they enjoy singing and dancing. I've also started activities such as shoe shining. [Name of person] enjoyed polishing his shoes, it brings back memories and there's the smell of the shoe polish. He was telling me when he used to do it when he was younger. [Name] used to develop his own photographs so I gave him a camera and we have chats about the photos…We also have coffee mornings and they bake their own scones and cakes. I also found an old box with things like old money and dolly blue [laundry product] and they loved talking about these."

We observed a singing and dancing session on the unit for people with a dementia related condition. There was much leg raising and swirling! Staff encouraged people to dance. One staff member said, "Come on, you're my dancing partner."

We saw that people were also encouraged to carry out housekeeping tasks. These are important because they help promote wellbeing and independence. One person enjoyed setting the table and wiping the table mats down after meals. Another person liked to tidy her own bedroom and make her bed.

The service was working with a 'creative ageing charity' called HenPower. We checked their website which stated, "HenPower creatively engages older people in arts activities and hen-keeping to promote health and wellbeing and reduce loneliness." The registered manager told us that the hens were not only a source of enjoyment for people, they also sold their eggs to raise money for the 'residents fund.' People had also been involved in an external arts exhibition. The registered manager told us, "Just because they may have dementia or are elderly, does not mean that they can't express themselves through art."

We had concerns however, about the social needs and inclusion of one person who was mostly cared for in bed. Night staff explained that the individual appeared not to enjoy being on their bed for long periods. We spoke with the interim manager about this feedback. She told us that the individual was at high risk of falls and pressure ulcers. They explained that she came to the dining room for meals.

We saw the individual was awake and lying on her bed when we first saw her at 7.30am. We visited her at various times in the morning and found her lying on her bed. There was no television on or radio. Hourly checks were documented, however these were tick box in nature and did not record what interactions had taken place. We read daily records relating to her care. These were mainly focused on her "bed rest." We also read the activities coordinator's social records. We noted she was often asleep when the activities coordinator visited or had been unable to take part in any activities because she had been "on bed rest." Her social assessment had not been completed. The staff member had recorded, "[Name] is incapable of talking to me and I don't see any visitors." We considered that the individual's social needs were not always met to reduce the risk of isolation.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation

9. Person-centred care.

We spoke with the registered manager about our observations. He told us that he would look into the concerns we raised. He reiterated that she was supported to go to the dining room for meals for a change of scenery and social interaction and also visited the hairdresser.

There was a complaints procedure in place. There were no active complaints. People and relatives we spoke with during the inspection raised no complaints about the service or the care provided. The registered manager told us, "My door is always open." He explained that it was important to deal with any minor concerns immediately to help prevent them developing into formal complaints. A "dignity and concerns" book was kept. Records of any issues relating to dignity and minor concerns were documented. We read entries such as missing laundry and what action had been taken to resolve the concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who had worked at the service since August 2013. We read the provider's website which included an introduction from the registered manager. This stated, "When I left the army after 25 years in the Guards, I was looking for the same sort of challenge and stimulation, and I didn't think I'd ever get it in civilian life. How wrong I was. As manager of Ashfield Court, not only is it a challenge, it's also rewarding. I meet lots of interesting characters, and learn a lot of things I didn't know and I have a lot of fun at the same time.

He was currently overseeing the management of one of the provider's nearby nursing homes. He explained that there was the possibility of him becoming manager at this nursing home. As a result, an 'interim manager' had been appointed who the manager explained would eventually take over his role as manager at Ashfield Court and would register with CQC. She had worked at the service for a number of years. The interim manager told us she felt well supported and the registered manager generally visited Ashfield Court every morning before going to the nursing home.

We were supported by both the registered manager and interim manager on both days of the inspection.

At our last comprehensive inspection in November 2015, we rated the service as 'requires improvement.' We found the provider was in breach of three regulations relating to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including 'Good governance' and one breach of the CQC Registration Regulations 2009. We carried out a focused inspection in June 2016 and found that improvements had been made. We did not change the home's overall rating at the focused inspection because to do so requires consistent good practice over time. At this inspection we identified a further three breaches including a repeated breach of 'Good governance.' This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

Regular audits and checks were carried out by the registered manager and interim manager to monitor all aspects of the service, including out of hours and night time checks. Audits were also completed by the regional manager and the quality and compliance manager. Action plans were formulated relating to any areas which needed attention such as training and documentation.

We found however, that these audits and checks had not highlighted the issues which had been identified during this inspection such as the culture and morale on night shift and concerns with certain staff practices and behaviours. Some night staff told us that they had raised concerns in the past about specific staff and care practices; however no action had been taken. Other staff told us that they had not felt able to raise specific concerns. Comments included, "When I go to managers they don't do anything" and "We don't get listened to."

We checked all of night staff's personnel files and supervision/appraisal records and could see no evidence of any concerns being raised. The registered manager told us that he was unaware of these concerns. We passed this information to members of the provider's management team to investigate.

We looked at night staff supervision sessions and appraisals. We noted there was no evidence of any supervisions in some of the files we checked and only one supervision record in others. We considered that an effective system to develop, monitor and review staff practices and behaviours was not fully in place to ensure staff were supported to deliver care which met people's needs.

We identified shortfalls in the maintenance of records relating to the MCA and there were omissions in one person's care documentation that we viewed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

Day staff, people and relatives were complimentary about the management team. Day staff told us that they enjoyed working at the home and morale was good. There was a low staff turnover on days and many staff had worked at the home for a number of years. There had been a higher staff turnover on nights. Many of the night staff had worked at the home for a year or less. The interim manager told us that no trends had been identified that may explain the higher turnover.

People and relatives were complimentary about the home. They told us, "I'm over the moon with it [the service]. I'm here every day," "It's B***** great here!" "No way could anything be improved," "It's 10 out of 10" and "It's good, I would say eight out of 10," "The atmosphere and feel of the place…It's like home from home." Surveys were also carried out and a 'You said, We did' summary was completed. The registered manager told us they had tried to initiate 'resident and relatives' meetings' however, no one had turned up to the planned meetings.

At our previous comprehensive inspection in November 2015, we found that the provider was not reporting incidents to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found that the provider was submitting notifications in line with legal requirements. The provider was displaying their CQC performance ratings both at the home and on their website in line with legal requirements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment did not always meet their needs or reflect their preferences. Regulation 9 (1)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not fully protected from the risk of abuse because safeguarding procedures were not always followed. Regulation 13 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not fully in place to ensure compliance with the regulations. There were shortfalls in the maintenance of certain records. An effective system to ensure that staff were supported and their behaviours and practices were monitored, was not fully in place. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(e)(f).